MALE PARTICIPATION IN REPRODUCTIVE HEALTH IN KIBERA SLUM

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2010
DECLARATION

This project is my original work and has not been submitted for a degree to any other University.

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3/11/2010

Date

This project has been submitted for examination with my approval as a University internal Supervisor

Dr. Owuor Olungah

3/11/2010

Date
DEDICATION

I dedicate this project to my wife (Carolyn O. Ochieng), my children (Timothy, Jennifer and Alfred), for their understanding, encouragement and support during the period. This success is all yours; because, without your support, I would not have made it.

To my parents and siblings for supporting me during my undergraduate and early years of education; you made my dream come true.

To all those who contributed in sharing their life experiences for the purpose of this study thus enabling the realization of the objective of the study, may God grant you your heart desires.

Last to all the men and women who are supporting, championing and advocating for gender equality, the world is not safe until we all say no to all forms of gender based discrimination.

Let the struggle continue.
ACKNOWLEDGEMENTS

My deep appreciation goes to the participants; respondents and key informants who created time to share their experiences, ideas and knowledge. Thank you. More so to the men and women of Kibera for their honesty and willingness to participate in this study; thank you for sharing your lives, passions and deepest concerns. I will always remember you in my prayers.

To Dr. Owuor Olungah, my supervisor who tirelessly guided me step by step when I lost direction in the project, thanks for your tireless efforts in helping me complete this project successfully.
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<th>Full Form</th>
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<tbody>
<tr>
<td>AMREF-</td>
<td>African Medical and Research Foundation</td>
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<td>APHRC-</td>
<td>African Population and Health Research Center</td>
</tr>
<tr>
<td>CBS-</td>
<td>Central Bureau of Statistics</td>
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<tr>
<td>FGD-</td>
<td>Focused Group Discussions</td>
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<td>FP-</td>
<td>Family planning</td>
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<tr>
<td>HIV/AIDS-</td>
<td>Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ICPD-</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IUD-</td>
<td>Intrauterine device</td>
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<tr>
<td>JHU-</td>
<td>Johns Hopkins University</td>
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<td>KANCO:</td>
<td>Kenya AIDS NGOs Consortium</td>
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<td>KAP-</td>
<td>Knowledge, Attitude and Practice</td>
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<tr>
<td>KDHS-</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>LAM-</td>
<td>Lactational Amenorrhoea Method</td>
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<tr>
<td>MOH-</td>
<td>Ministry of Health</td>
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<tr>
<td>MSF-</td>
<td>Medecins Sans Frontieres</td>
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<tr>
<td>POA-</td>
<td>Programme of Action</td>
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<tr>
<td>RH-</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SPSS-</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>STD-</td>
<td>Sexually Transmitted diseases</td>
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<tr>
<td>STI-</td>
<td>Sexually transmitted Infections</td>
</tr>
<tr>
<td>UN-</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS-</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>UNFPA-</td>
<td>United Nations Population Fund</td>
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<td>WHO-</td>
<td>World Health Organization</td>
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ABSTRACT

Immediately after the International Conference on Population and Development (ICPD) in Cairo, most countries (Kenya included) embarked on the process of domesticating the ICPD Programme of Action. In Kenya, this process culminated in the development of a policy document titled, The National Population Policy for Sustainable Development, which was approved by Parliament as a Sessional paper No. 1 of 2000.

Though the government of Kenya, in her National Reproductive Health Strategy developed in 1996, had prioritized, "Provision of Comprehensive and integrated system of reproductive health care and services" these services have not been fully realized by all because; most men remain passive participants on reproductive health issues. This study therefore, set out to establish the level of male participation in reproductive health in Kibera.

A total of 35 men, currently married or in intimate relationship, and living in Kibera were interviewed through survey questionnaire on their knowledge, level of participation and what they considered as obstacles to male participation in reproductive health. Women participated through focused group discussions, a total of three focused group discussions were organized and attended by 20 women, drawn from organized women groups in Kibera. Key informants provided information that further enriched the data collected from the survey and focused group discussions.

The study found that most men are knowledgeable on contraceptives and reproductive health issues, as all were able to name at least one contraceptive method. The most widely known contraceptive by men is condom; however, this knowledge is not necessarily translated into practice, especially with their wives/regular girlfriends. The level of knowledge is influenced by among other factors, the level of education and access to information. The level of male participation in reproductive health is still generally low, though there are opportunities to enhance their involvement. The obstacles to male participation in reproductive health; are more of structural and cultural (socialization) in nature, which can be overcome through partnership and stakeholders’ participation in the health sector. This need to be guided by guidelines developed, coordinated and financed by government.
1.0 CHAPTER ONE: BACKGROUND OF THE STUDY

1.1 Introduction
Since the International Conference on Population and Development (ICPD) in 1994 in Cairo, there has been a paradigm shift away from programs focusing solely on women’s health and family planning towards sexual and reproductive health more generally. For too long, men’s sexual and reproductive health needs were overlooked. And yet significant numbers of men, particularly in poorer countries, still engage in unprotected sex. Men want and need reliable and accessible information and services that can help them lead healthy sexual lives, but often they do not get them, especially in developing countries (Guttmacher, 2002). While men have specific and often neglected needs, their roles and responsibilities also impact on the health and well-being of women and children (Power and Kenyon, 2005).

The Programme of Action of the International Conference on Population and Development (ICPD, 1994) was domesticated by Kenya in the National Population Policy for Sustainable Development. The broad goals and objectives of the policy included, among others in the area of: reproductive health and reproductive rights, adolescents reproductive health, gender perspectives and HIV/AIDS.

The International Conference on Population and Development (ICPD) was one of the first international conferences to recognize the male role in reproductive health (ICPD 1994). Its Programme of Action (POA) stated: Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescent and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for prevention of sexually transmitted diseases.

As a follow up to the recommendations of the ICPD, the National Reproductive Health Strategy in Kenya was developed in 1996. This was the first activity to operationalise the reproductive health agenda as recommended by the ICPD. The overall goal of the Strategy was the provision
of a comprehensive and integrated system of reproductive health care that offers a full range of services.

The ICPD marked a major shift in the mental framework on reproduction and emphasized the right and capability of people to choose freely and responsibly in the domain of reproductive health. It also highlighted the responsibility of men to be involved in family reproductive health, responsible parenthood and gender equality (United Nations 1994).

A growing number of family planning and other reproductive health care programs and providers are of the opinion that men deserve more attention not only for their own sake, but also for women's sake, and for the health of their families and communities. From this new perspective, men are potential partners in advocating for good reproductive health rather than bystanders, barriers, or adversaries (Population Report, 1998).

Both male and female reproductive systems play a critical role in reproductive health and any problems with them can be harmful to the overall health and can impair a person's ability to enjoy a sexual relationship. Given the importance of male participation in reproductive health, the focus for this project was therefore, to explore the level of male participation either as husbands and/or intimate sexual partners in Kibera Kenya.

The outcome of the study was expected to come up with suggestions and views on how to enhance male participation as a way of promoting gender equality in matters reproductive.

1.2 Problem Statement

A report by Kanco (2006) indicates that men's reproductive health needs remain invisible and have so far received inadequate attention in Kenya. However, men's behavior puts them and women at risk of HIV infection mainly through unprotected sex.

The report further indicated that, in African (Kenyan) communities, women were not able to negotiate for safer sex, demand faithfulness or encourage men to abstain due to gender and power imbalances. Men determined the nature of sexual relations to undertake with women
which is often driven by their own pleasure. Moreover, male sexuality is also thought and described in many societies as potent and uncontrollable (Campbell, 1997:278).

In a reproductive health research conducted by the government of Kenya in 2004, the government admitted that, there was a slow pace in meeting overall targets of reproductive health and well being of its citizens, especially men (MOH, 2004:4).

In the traditional male role, the husband is responsible for the economic well being of the family, while the wife is in charge of everything else, including reproduction and especially child rearing and home care. Most men view their wives principally as mothers of their children, as housewives, and as “objects” to be “used” for sexual gratification rather than as companions or social equals, thus giving men the excuse of not participating in reproductive health issues (Folch-Lyon, 1981).

An estimated 488 women per 100,000 live births die as a result of pregnancy related complications, and childbirth in the postnatal period, making maternal death one of the leading cause of death among women of the reproductive age in Kenya (KDHS 2008-09). According to the findings of KDHS 2008-09, although overall female mortality rates were lower than those of 2003, the report noted that maternal mortality estimates are subject to larger sampling errors than are adult mortality estimates. In the case of the 2008-09 KDHS, there was a small increase in the maternal mortality rate (0.8 in 2008-09 and 0.6 in 2003) accompanied by a fall in the age-standardized general fertility rate (0.161 in 2008-09 and 0.166 in 2003); hence, there was an elevated maternal mortality ratio.

Having sex with multiple partners has implications for reproductive health because wider sexual networks lead to increased exposure to infections, men age 15-49 are nine times more likely than women to have had two or more sexual partners in the 12 months before the survey (9 percent and 1 percent). This pattern however showed that there was a slight drop in multiple partnering, from 12 percent of men and 2 percent of women in the 2003 KDHS. The 2008-09 data further showed that men were twice as likely as women to have had intercourse in the past 12 months with a person who was neither their spouse nor who lived with them (25 percent and
13 percent). Among respondents who ever had sexual intercourse, the mean number of lifetime sexual partners was considerably higher among men (6.3) than among women (2.1) (KDHS 2008-09).

The KDHS (2003) data further indicated that, despite a relatively high level of contraceptive use, unplanned pregnancies were common in Kenya, with 20 percent of births being unwanted, while 25 percent were mistimed (wanted later). Compared with the 1998 KDHS; however, the trends showed a sizeable increase in the percentage of births that were unwanted. Unintended pregnancies expose women, especially poor women, to health risks simply by increasing the number of pregnancies and deliveries in their lifetimes.

The survey further points out that, modern life style that may require married partners to stay a part, increased migration and urbanization, increased materialism and relative impoverishment within the societies has led to the rise in commercial sexual activities, exposing reproductive health systems to more risks of infections and ill-health (ibid).

Patriarchal traditions in Kenya have long excluded men from participating in discussions regarding sexual and reproductive health. The situation in reproductive health is characterized by premature and unwanted pregnancies, high maternal mortality, inadequate services for adolescents and female genital mutilation affecting 37% of all women in rural areas (KDHS, 2003).

The reason why most reproductive health initiatives have not been able to achieve the desired results can be attributed to lack of men’s participation in reproductive health initiatives. This is the gap which the study set out to address.

The research questions which guided the study were as follows;

- How knowledgeable are men in reproductive health?
- What is the level of male participation in reproductive health?
- What are the obstacles to male participation in reproductive health?
1.3 Study Objectives

1.3.1 Overall Objective

The overall objective of the study was to examine the level of male participation in reproductive health in Kibera slum.

1.3.2 Specific objectives

- To determine the level of men's knowledge on reproductive health.
- To establish the levels of male participation in reproductive health.
- To assess the obstacles to male participation in reproductive health.

1.4 Justification of the study

Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. With HIV now spreading faster among women than among men in some regions, the AIDS epidemic has focused attention on the health consequences of men's sexual behavior. Also, millions of pregnancies are unintended, and each year many thousands of women die as a result of these pregnancies.

While reproductive health needs of women have been placed squarely on the research and policy agenda, there are still many unanswered questions about issues related to male reproductive health (Mbizvo, 1996).

It is generally acknowledged that gender-based customs and ideas affect men's behavior, but there is a notable lack of research on men's understanding of gender issues and their impact on men's health in sub-Saharan Africa (Courtenay, 2000).

Lessons learned from successful reproductive health programmes around the world, especially in developing countries such as India, Bolivia, Indonesia and Mexico, showed that men's
positive attitudes and beliefs regarding reproductive health have led to successful programmes (UNFPA, 1995).

Report by UNFPA indicate that the care and support of an informed husband improves pregnancy and childbirth outcomes and can mean the difference between life and death in cases where women need immediate medical care (UNFPA 2005).

The justification provided for this study is that while women bear greater health hazards associated with reproduction than men, it is men who are largely responsible for contributing to these hazards, thus the need to explore their level of participation in reproductive health.

The study intended to provide recommendations that would be used to inform policy and programme formulation in reproductive health broadly, but especially, on male participation in reproductive health.

1.5 Scope and limitations of the study

The study was restricted to persons of ages 18 to 65 years old, living in Kibera and are either married or are in an intimate relationship.

The study was limited to only three villages in Kibera of the larger Nairobi; this may have a significant effect on the external validity and generalization of the data collected.

The other limitation may have emanated from possible unnoticed biases which might have arisen from the use of different interviewers, who may have influenced the data collected through their own understanding and might have influenced responses through their physical presence, or interviewer biases.
2.0. CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction
This chapter presents literature review that include articles, journal, research papers, published and unpublished works related to men’s participation in reproductive health in general and specifically in Kenya as expounded by various scholars.

Equal participation of men in sharing power over reproductive decision-making and in creating healthy and responsible sexual relationships with their partners is seen as both a means to promoting women's rights and gender equity, and an end in itself (Greene and Ann, 2000).

While masculinities and femininities are historically and socially constructed there are also relational constructs; the definition of one depends on the definition of the other. In the words of Bourdieu (1998), the basic notion of femininity and masculinity as well as female and male sexuality reflects a number of fundamental and competing oppositions and differences.

Bourdieu claims that, ideas about femininity are associated with the private sphere and with traits that suggest passivity and subordination; ideas about masculinity on the contrary, are associated with public sphere, and with authority and dominance.

Judith Butler (1990) asserts that; the sexual aspect of masculinity depicts manhood as sexually dominant, active, controlling, and above all, as penetration. The fact that masculinity is rooted in the institution of heterosexuality leads to specific meanings of gender, she explained.

Butler explored the concept of “heterosexual matrix”: The heterosexual matrix is a hegemonic discursive/epistemic model of gender intelligibility that assumes that for bodies to cohere and make sense there must be a stable sex expressed through a stable gender (masculine expresses male, feminine expresses female) that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality.

Men's acquisition of power requires, for example, that men suppress their needs and refuse to admit to or acknowledge their pain, denial of weakness or vulnerability, emotional and physical
control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behavior and physical dominance (Kaufman, 1994).

The urge for finding ways to stem the HIV/AIDS epidemic has drawn attention to the critical role of male participation. Transmission of the virus from men to women through unprotected sex is much more likely than vice versa. Risky behavior, like having multiple partners without using condoms, and male dominance in sexual decision making are important reasons to target men in AIDS programmes and campaigns (UNAIDS, 1997).

AIDS prevention campaigns have, moreover, promoted abstinence, faithfulness, and condom use. However, condom use requires partner co-operation, whereas abstinence is almost impossible as a strategy, given that adults are almost universally involved in sexual activity (Parker & Ehrhardt, 2001).

In addition, promotion of faithfulness ignores the reality that sexual relationships are often serial, and that partners are often not truthful about their sexual behavior (ibid). Similarly, proposing the use of a condom questions the image of trust a partner may wish to convey within a love relationship (MacPhail & Campbell, 2001).

2.2 Men's knowledge on Reproductive Health
The study of personal behavior in 1960-1970 by a conservative behavior group using knowledge, attitude and practice (KAP) model, namely the concept of behavior happening by relationship of three factors, revealed that, the behavior of a person demonstrates the inter-linkage between knowledge and attitude; knowledge changes attitudes and bring them to practice (Zimbardo and Muslach, 1977:49).

It can therefore be explained that the attitude of the person depends on knowledge, which is to say that; if a person had good knowledge of some thing; the attitude about it is likely to be good and affects the practice. The attitude of the person affects the mental feelings, which stimulate behavior. Thus, behavior of human action is affected by experience, knowledge, belief, learning and past events; however, good knowledge does not always cause good behavior.
Lack of awareness and misinformation regarding contraception among men also influences the non-acceptance and use of contraception on their wives (Odhiambo, 1997). Furthermore, because of lack of knowledge, men often perceive reproductive health problems with shame and embarrassment; and whenever they seek medical treatment, they often visit untrained healthcare providers (Singh et al, 1998).

If the spouse has correct knowledge of family planning or contraception, it will affect the number of children desired by the couple and leave space for each child, or at some point stop birth permanently by sterilization (Kasama, 1991:44).

Kanco, 2006 report states that, there exists pervasive silence surrounding male sexuality. The society expects men to be knowledgeable about sex and sexuality. Men may therefore, feel uncomfortable seeking for information or help when it is required. It is hypothesized that, men generally feel uncomfortable discussing intimate issues with partners culminating into grey and unknown sexual health needs of male gender.

A study by Passara revealed that contraceptive knowledge significantly related to selection of contraceptive method, while good knowledge of maternal and child health by the husband promoted more ante-natal care and increased men’s participation (Passara, 1992:92).

Traditionally, men associate condoms with reduced pleasure or prostitution, while in some cultures (i.e Luos of Kenya), condom use are associated with promiscuity and their association with disease prevention is seen as a draw back to their use, especially with married couples. A report by Demographic Research (2003) entitled “Social Interactions and HIV/AIDS in Rural Africa – a case of South Nyanza” indicate that condom use is not an appropriate protective method within close and intimate relationships. The study found out that, more men than women had sexual intercourses with prostitutes in three locations (Obisa, Owich and Wakula South) in South Nyanza and that men reported mostly using condoms with sex workers/prostitutes and less with their wives. On the other hand, it is accepted in the context of sex workers and therefore, men’s perception that, sexual intercourse with prostitutes puts them at risk of infection and not with their wives or regular girlfriends (Watkins, et al, 2003: 422).
When men were asked whether they agreed or disagreed that women who use contraceptives were likely to become promiscuous, the results indicated that 4 in 10 men believe that women who use family planning may become promiscuous (KDHS 2008-09).

In Kenya and elsewhere in most sub-Saharan African societies, parents’ communication about reproductive health issues is restricted. Adolescent research in Kenya indicates that such a situation is due not only to the general feeling of embarrassment from parents and children to discuss sexual matters, but also to the fact that parents, especially male parents are usually less knowledgeable of reproductive health issues than their adolescent children (Gary and Rich 1992).

In a review on reaction to AIDS in Sub-Saharan Africa, Caldwell asserts that there was an under-reaction to the epidemic. This arose from societies' lack of discussion of sexual relations between the sexes and the generations (Caldwell, et al, 1992).

Social interaction may be one mechanism for the exchange of contraceptive information. Studies in Kenya and elsewhere have demonstrated that women frequently talk to one another about fertility and contraceptive use during the course of their daily routine unlike men (Rutenberg and Susan, 1997).

According to Mbizo (1996), often, the spread of information about issues in reproductive health is verticalized by programme, e.g. family planning, rather than taking a holistic picture of socioeconomic and reproductive health issues. This frequently leads to people not acting on the knowledge they possess. This is true of contraceptive use, for example, where knowledge is very high but use remains low and family sizes remain high due to socio-cultural, political, economic and gender factors, relating mainly to lack of female control over decisions on fertility.

The KDHS (2008-09) research findings indicate that, though the knowledge of family planning methods is universal (95 percent of women and 97 percent of men aged 15-49 know at least one method of family planning), men are only slightly more likely to have heard of a specific
method than women, nevertheless, women have heard of more methods than men, on average (7.5 vs. 6.6), and that men are more likely to know about male and female condoms, male sterilization, the rhythm method and withdrawal.

The knowledge of methods to avoid HIV transmission is generally widespread in Kenya. For example, 81 percent of men know that the chance of getting HIV can be reduced by using condoms. Similarly, 93 percent of men know that limiting sex to one faithful partner reduces chances of getting HIV. Almost 90% of men know that abstaining from sex reduces the chances of getting HIV (KDHS, 2008-09).

The survey (KDHS, 2008-09) further indicates that urban dwellers are more knowledgeable about all methods of reducing the risk of HIV infection than their rural counterparts. The level of awareness shows marked differences across provinces. North Eastern province has the lowest levels of knowledge for all methods of reducing the risk of contracting HIV/AIDS, whereas Nairobi and Central province tend to have the highest levels of knowledge.

Furthermore, despite a relatively high level of contraceptive use, the 2008-09 KDHS data indicate that unplanned pregnancies are common in Kenya. Overall, 17 percent of births in Kenya are unwanted, while the proportion of mistimed (26 percent) has hardly changed since 2003 KDHS survey.

It can therefore, be concluded that even though men have information and knowledge on reproductive health, there is a gap between knowledge and practice.

2.3 Levels of male participation in Reproductive Health (Safe Sex and Family Planning) in Kenya

As defined by WHO and adopted in 1994 in the International Conference on Population and Development (ICPD, Cairo), Programme of Action, "Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all the matters relating to the reproductive system and its functions and processes."
Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (ICPD 1994).

The ICPD (1994) pointed out that men’s roles have been very important to family planning and reproductive health, especially in decision making about contraception. However, men did not appear in the family planning target which has caused a low contraceptive rate and decreased contraceptive efficiency. In addition, the action plan promoted responsibility of men in sexual behavior, fertility and family duty and increased opportunities of women in society.

It is pointed out that, in order to promote men’s participation in reproductive health, priority must be given to the provision of information, knowledge of family planning and reproductive health to men; according to the report, if men have good knowledge, they will benefit themselves and their wives. The knowledge about sexually transmitted diseases and Aids is helping change behavior and promoting condom use to prevent diseases (UNPFA, 1995).

The report also highlighted the need to encourage joint decision-making by spouses that is; men should provide wives or sexual partners with knowledge about family planning and reproductive health; the need to provide contraceptive choices, designing convenient and appealing services for both men and women, and promoting positive image of men and women about family planning.
2.3.1 Safe sex

The happiness of a spouse comes from the right practice of sexual intercourse. According to Anak, (1982:30) if spouse does not understand, has bad attitude or is not ready for sexual intercourse, it will decrease love and happiness, and some spouses may even divorce.

Economic dependence of poor women on men is highest and their empowerment lowest leading to low negotiating power for safe sex so that they are potentially most vulnerable in terms of HIV infection, in particular in circumstances of conflict within the household (UNAIDS 2001).

In matters of safe sex, a study by Arnfred (2004) revealed that condoms are now more readily available and are frequently used in urban set-up during sexual intercourse especially by a stranger; however, the study is quick to note that; there is lack of continuous use of the condom after several encounters. Arnfred found that when a man has had intercourse with a new partner a few times, that person is no longer a stranger, and condom use is stopped.

It is difficult, perhaps almost impossible for women (married women in particular) to negotiate safe sex measures-even if the women in many cases have an upper hand in the household.... Women agree that to ask the husband to use a condom-when they know that he has been with other partners-would be to disclose their disrespect too openly... the common argument from both Nyumba Ndogos (mistress/concubines) as well as ‘wives’ were that if they insisted on condom use, their partners/husband would be suspicious and then have a reason to accuse them of not being faithful (ibid: 239).

Gay men may also refuse to engage in behavior that reduces the risk of contracting AIDS when that behavior contradicts dominant norms of masculinity: "Real men ignore precautions for AIDS risk reduction, seek many sexual partners, and reject displeasing the penis. Abstinence, safer sex, and safer drug use compromise manhood" (Dutton and Levine, 1989:146)

The cultural factors that are inhibiting proper and efficient use of condoms in western Kenya include the fact that a woman is usually not supposed to see a man naked - thus the sex act is performed in complete darkness, a major challenge to the (male) users who need light to wear
condoms correctly. Other factors include cultural events during which free sex is allowed, and secrecy that surrounds the sex act. One is not supposed to let other people know that they are planning to have sex. Therefore purchasing condoms from local shops or vendors is a major feat that is achieved by only a few since it amounts to an open announcement about one's intentions as far as sex is concerned (Wamalwa and Nyanjom, 2004).

Sex in most, if not all traditional cultures in Kenya, serves the purpose of matrimony and parenthood, thus, in general, pre-marital sex was discouraged since it did not serve the purpose of matrimony and parenthood and stiff fines were meted out to people who committed adultery (Wagner, 1970: 379).

2.3.2 Family planning

Family Planning can be defined as the conscious effort of couples to regulate the number and spacing of births through artificial and natural methods of contraception. Family planning connotes conception control to avoid pregnancy and abortion, but it also includes efforts of couples to induce pregnancy (www.whiteribbonalliance.org/).

Most data concerning family planning have focused on the study of contraceptive knowledge and adoption amongst women. The findings point to a disproportionate emphasis on methods that target the female partner. In Zimbabwe, 53% of men reported having knowledge of female sterilization against only 2% with unprompted knowledge of male sterilization. The study also demonstrated that marriage was practically universal and whereas contraceptive prevalence was high, in the majority of cases (64%) men had responsibility for deciding on contraceptive adoption and family size (Mbizvo, 1996).

Family planning comes with a number of benefits these include; avoiding undesired pregnancies, getting a child when parents are at an appropriate age and enables a couple to have an appropriate number of children (Waree and orapin, 1985).
Family planning is a responsibility of both men and women, where the contraceptive method could be for both men and women; some of the contraceptive methods for men are; permanent contraception (sterilization) and temporary contraception-condom, coitus interruptus and periodic abstinence (Vitoon, 1991).

Knowledge of family planning is nearly universal, with 95 percent of all women and 97 percent of men age 15 to 49 knowing at least one modern method of family planning. Data by background characteristics show that awareness of family planning methods is widespread. The proportion of currently married women and men who have heard of at least one contraceptive method exceeds 90 percent in all categories by age, residence, education, and wealth. Exceptions are found among women with no education, women in the lowest wealth quintile, and women in North Eastern province, where less than half of married women have heard of any method (KDHS, 2008-09).

The attitude of men does not constitute a major obstacle to family planning but generally, in most developing countries, men have a more reserved attitude toward contraception than women. In a study in Cameroon, it was found that, 64% of men in the rural areas of Akonolinga and 63% in the rural areas of Obala are favorable to contraceptive practice, while another study among University students in Yaoundé showed a favorable attitude in 92% of unmarried couples and 98% of married couples (http://www.gfmer.ch/Books/Reproductive_health...html).

Family planning methods can be classified into two categories, modern and traditional methods; modern methods are more familiar to women than traditional methods; 95 percent of women know at least one modern method, and only 69 percent know a traditional method. Among women, the most widely known modern methods of contraception are male condoms, injectables, and pills, with about 89 percent of all women saying they know of these methods.

The least known methods among women are the lactational amenorrhoea method (LAM), male sterilization, and emergency contraception, which are known by 40 percent or less of all women. Around 6 in 10 women have heard of female sterilization, the IUD, implants, and the female condom. With regard to traditional methods, about two-thirds of women have heard of
the rhythm method, and just under half know about withdrawal, while folk methods are the least likely to be mentioned (KDHS, 2008-09).

The dominant male views on condoms as a method of family planning is that, condoms are associated with unfaithfulness and therefore not acceptable in most stable sexual relationships. The introduction of condom use in a long-term relationship, where they have not been previously used, may threaten the trust that is implied (whether it exists or not) in most of such relationships. Changanti observed that for most married men and women, condoms were associated with outside partners hence should be used only for casual sex and with prostitutes (Changanti, 1994).

Condoms are effective, but only if used correctly with every act of sex. Globally, when used consistently and correctly, only 2 out of every 100 women whose partners use condoms become pregnant over the first year of use. Many people, however, do not use condoms every time they have sex or do not use them correctly (Family planning 2007).

Vasectomy is the male sterilization operation that blocks the **vas deferens** to prevent the passage of sperm into the ejaculated seminal fluid. The “no scalp” approach uses a different anesthetic technique and reaches the vas deferens through a puncture in the scrotum rather than an incision made with a scalpel (Hatcher, et al 1998). Vasectomy has a probability of pregnancy of 0.1% in the first year (ibid). It is simpler, safer, less expensive, and more effective than female sterilization.

Vasectomy is very often ignored, despite its being one of the safest, simplest, most highly effective, and least-expensive contraceptive methods. Vasectomy remains the family planning method that is least known, understood, or used, a fact confirmed in Demographic and Health Survey (DHS) studies conducted in 21 countries over the past five years. For example, in Sub-Saharan Africa, except for Ghana, Kenya, Malawi, and Uganda, the majority of men had not heard of vasectomy (United Nations, 2005).
The use of vasectomy in the world varies significantly by region and country. Almost three-fourths of the 37 million couples who use vasectomy live in Asia with China and India alone accounting for more than two-thirds of this total. Vasectomy rates in almost all of Africa are 0.1% or less, although vasectomy services have been introduced within a number of Sub-Saharan African countries, such as Ghana, Kenya, Malawi, and Tanzania (UN, 2005).

Men persisted in the belief that family planning is a woman’s responsibility, and many confused the procedure of vasectomy with castration (Lynam et al., 1993). A survey for a project on male involvement in Family Planning found that only 22% of men and 31% of women approved of vasectomy (Mwarogo et al., 1996).

2.4 Obstacles to male participation in Reproductive Health

Men’s low acceptance and near rejection of family planning is due to numerous reasons, according to preliminary findings of a joint study by the Kisumu Medical Education Trust – a community based organization involved in provision of reproductive health services in western Kenya – and Boston University (UNFPA, 2009).

Research conducted between December 2008 and January 2009 in Rift Valley, Nyanza and Western provinces; found that most men were reluctant to visit reproductive health clinics for advice on family planning because they viewed the facilities as a ‘women’s place’, and did not want to mix with women for fear of being seen to be henpecked or considered effeminate (UNFPA, 2009).

The overriding factors are widespread myths and misconceptions about family planning for women and men. A majority of the male respondents indicated that family planning made a woman cold in bed, while many others elicited fears that vasectomy would render them unable to have sex. They held that this would harm their standing in society, as well as cause their spouses to look for other partners (www.unfpa.org/public/News/pid/3015).
Zaddock Odhiambo, a 28-year-old and father of six remarked that, “family planning makes women promiscuous and would never advise the wife to use those things (contraceptives) because the role of a woman is to give birth to children” (www.unfpa.org/public/News/pid/3015)

A study of male participation in family planning results from a qualitative study in Mpigi District, Uganda, indicate that men have limited knowledge about family planning, that family planning services do not adequately meet the needs of men, and that spousal communication about family planning issues is generally poor. However, almost all men approved of modern family planning and expressed great interest in participating. The positive change of the beliefs and attitudes of men towards family planning in the past years has not been recognized by family planning programme managers, since available services are not in line with current public attitudes. A more couple-oriented approach to family planning is needed. Measures could include, for example, recruiting males as family planning providers, offering more family planning counseling for couples, and promoting female-oriented methods with men and vice versa (www.ncbi.nlm.nih.gov/pubmed/15906884)

2.4.1 Attitude towards reproductive health

According to literature from John Hopkins University, many men have negative attitudes towards contraception by women, some men fear that contraception will affect their sexual intercourse and may encourage the wife to have sex with other men (John Hopkins University 1998).

A study of male factory workers in Harare, Zimbabwe established that few married men, who tested positive for HIV infection, used condoms with their wives although they reported using them with other sexual partners (Mbizo et al. 1994). This example illustrates the urgent need for interventions designed to change male sexual behavior.

Traditionally, men associate condoms with reduced pleasure or prostitution. In some cultures, condoms are associated with promiscuity and their association with disease prevention is seen as a draw back to their use with the wife, such attitude make men suspect their wives whenever they insist that, husbands have to use condoms (Rwabukwali, 1991).
The socialization of young women to acquiesce to spouses in sexual encounters and to give priority to male pleasure and control in sexual partnerships can contribute significantly to women’s inability to negotiate when, where and how sexual intercourse takes place (Family Health International, 1999).

The socio-cultural context can influence people’s perceptions and attitudes through internalization of specific sexual beliefs, norms and practices. In Nyanza and parts of Western Province, the practice of widow inheritance, polygyny, a belief in witchcraft and chira (a Luo term for a body-wasting illness that is believed to afflict people who break cultural taboos), are entrenched components of the Luo and Luyha culture which have been associated with the rapid spread of AIDS (Kenya et al., 1998; Ocholla-Ayayo, 1976).

It has been suggested that African societies are more tolerant of men’s infidelity than women; this is because of the practice of postpartum sexual abstinence (Ocholla-Ayayo & Schwartz, 1991).

Differentials in power may enable one partner to unilaterally reject the use of condoms. Many women in African societies depend on the economic support provided by men and thus transactional sex can become important in various phases of their lives. A study in Kenya showed that both men and women report objections to condom use by their partners (Waithaka et al., 2001).

2.4.2 Socio-economic factors

Socio-economic status is defined by Dutton and Levine, as a composite measure that typically incorporates economic status, measured by income; social status measured by level of education and work status measured by occupation (Dutton and Levine, 1989:30).

Throughout history, socio-economic status has been linked to health. Individuals higher in the social hierarchy typically enjoy better health than those below; socio-economic status is found
to influence the rates of mortality and morbidity from almost every disease and condition (Illsley and Baker 1991).

At the micro level (household) poverty potentially increases vulnerability to HIV via compromised reproductive health or reduced HIV/AIDS awareness. The poor are less likely than the wealthy to know about prevention behaviors and less likely to have had an HIV test (Glick and Sahn, 2007).

Education affects the knowledge, thoughts, and understanding in life and in society. These affect positively or negatively the participation of men in family and community activities. Higher education increases Aids prevention behavior (Bussaba, 1991).

Greater attainment of education, particularly by women, has been recognized as an important factor in increasing contraceptive use and reducing fertility, and while educational attainment is an important factor in accounting for differentials in contraceptive use between individuals in a given population, the attainment of mass or universal education is very critical for the onset of fertility transition (Caldwell, 1987).

Discussions on family size preferences has been shown to take place in families where the male partner had more years of schooling compared with less-educated men (Gibney, 1993).

A study about factors which influence condom use or non-use for high risk men and the husband’s self practice for Aids prevention, found out that the occupation affected the use of condoms, according to Odhiambo (1997), the occupation of a husband positively correlated both directly and indirectly to the contraceptive utilization. The husbands with higher occupation had more contraceptive use than husband who had a lower occupation; this is attributed to the access to information through various means of information, education and communication channels.
2.4.3 Family type and spousal relationships

A study by Vilawan (1988) revealed that a good spouses’ relationship positively relates to a fathers’ role in safe sex and family planning. In a spouses’ relationship in which one of the partners was communicative, it was found to be an important factor in increasing men’s participation in reproductive health (Vilawan, 1988).

Studies (John H.U 1998; Odhiambo, 1997), reveals that if the wife and husband have a good relationship, they increasingly consult about family planning and use of contraception, it can therefore be said that there is a strong positive association between spousal discussion about family planning and contraceptive use. Differentials in prevalence of contraception according to frequency of husband-wife discussion of family planning were almost identical to differentials by education. Women who discussed family planning with their husbands made considerable gains in contraceptive use between 1989 and 1993. However, hardly any increase occurred among women who never discussed family planning with their husbands. This underscores the importance of husband-wife communication about family planning for both the acceptance and sustained use of contraceptives (Rutenberg and Susan, 1997).

In a study by Prampree, he demonstrated that fathers in nuclear families participate in reproductive health matters more than fathers in extended families (Prampree, 1998).

2.5 Conceptual Framework

The research used a conceptual framework of Machismo/traditional masculinity, which propound that men and women are intrinsically different; and that they have sex specific personality traits and therefore are suited to occupy separate positions within the society (Alsop et al, 2006).

The meaning of the concept as used in this study was borrowed from the definition by Villereal and Alonzo 2005; who defined Machismo as a group of attitudes that allows the male to overly
assert his presence on women, but also around other men (as is the case of excessive alcohol abuse).

The concept of Machismo is defined as a strong sense of masculine pride, or exaggerated exertion of masculinity, or male-like qualities. It is derived from the Spanish word *macho*, literally meaning male or masculine, and through time it has come to be the defining characteristic for males in Latin America. This umbrella term has become the definition, and ultimately the justification, for all acts by males (Rasheed & Rasheed, 1999).

According to Rasheed, some of the characteristics of traditionally sanctioned masculinity include aggression, rejection of “feminine”, preoccupation with sex, being an economic provider, sexuality, and being the protector of home and family (Rasheed & Rasheed, 1999).

Richard Dawkins’s (1976) argues that men’s genetic make-up makes them programmed to philander (have casual sexual affairs with women) in order to maximize their reproductive potential. This explains traditional expectation about men's behavior, where traditional masculinity opposes anything associated remotely with femininity, equating it with passivity and helplessness (Hong, 2000).

Alsop (2006) drew on the sociobiology to argue that men and women are genetically programmed to follow different paths. Men he argued are victims of their biological make-up, the human males’ thoughts, wills and actions are driven by forces outside his control.

Brando and Lindsey (1994), maintained that in every human culture, men are propelled by genetically ordained impulses over which they have no control to distribute their seed into as many females as possible, they argued that men are driven by a force they know not of to make love, procreate and reproduce.

UNAIDS (2001), men are under pressure to conform to often destructive ideas about what it is to be a man, ideas that emphasize sexual prowess, multiple sexual partners, and risk-taking. Obviously, these ideas place both sexes at greater risk of HIV and STIs (UNAIDS, 2001).
According to Jackson (2002), young males that exhibit characteristics of laddishness; principally female characteristics, exhibit a higher degree of underachievement when compared to males that conceptualize their personality as masculine.

Traditional masculinity has also been found to be associated with emotional inexpressiveness in general and with higher thresholds of pain specifically (Eisler, 1995). The reluctance to acknowledge or report physical or emotional distress can have far-reaching implications for men’s health; it can influence help-seeking decisions, delay intervention, and undermine diagnosis and treatment planning.

Men and boys experience enormous social pressure to adopt these beliefs, and in general experience comparatively greater social pressure than women and girls to endorse societal prescriptions about gender (Courtenay, 2000c). Boys experience more ridicule and are punished more severely than girls—by both peers and adults—for engaging in nontraditional or non-stereotypical “boy” behavior (e.g., expressing hurt or asking for help). The contexts in which men and boys live, work, and play often foster unhealthy forms of masculinity (Courtenay, 2000). In many of men’s sports, for example, the use of aggression, the acceptance of health risks, and the denial of pain are both rationalized and glorified (Courtenay, 2000c). This is the conceptual understanding that formed the foundation of this research.

2.5.1 Relevance of the concept

The concept of Machismo was used in this study to demonstrate how socialization of children has a bearing in their future roles as husbands and wives.

The concept represents the cultural attitude that is commonly adapted by the males in most patriarchal societies, in this case Kenya; it is transmitted from older men to a young male. Ascribing to machismo had both positive and negative influence on the roles for men; to be born a male in a patriarchal society is of high prestige and valued more than if one was born female. In patriarchal societies, women are raised that one day they will marry a man and that
the man will be in charge of the family and the family must obey him. This echoes the view of most men in patriarchal society.

It is important to note that the concept of machismo can be positive in the form of a man taking care of the family, working hard for money to support the family, and taking pride in the raising of children as a sign of a successful man; while negative machismo includes aspects of violence to women and other males, alcoholism, and having other sexual partners besides one's wife (Villereal and Alonzo, 2005).

In terms of reproductive health, the concept of machismo, where a Man is supposed to provide for his family can be used by Men to help women stay healthy by planning their families with their partner, limiting and spacing their children, providing good nutritious foods, assuring that a trained attendant is present at the delivery and paying for these professional services.

According to Kisekka (1997), men's uninvolvement or worse, support of doctrines that repress women contribute to maternal mortality. He further explains that where strict seclusion of women is observed, for instance, women require their husband's permission to seek health care, even during childbirth. Serious damage to the health of the mother or child, or even maternal mortality, may result from the husbands' absence (Kisekka, 1997). These factors play a role in the high mortality rate in northern Nigeria, where the ratio is greater than 1,000 maternal deaths per 100,000 live births. In this predominantly Islamic culture, which undervalues women and where women's reproductive needs are under strict male control, women's access to medical care is restricted.

One of the male respondents in Kianda said that a real man is born and brought up to be the head of the household, and that for him and his siblings, their mothers raised them to be men, and that man must be strong and be able to handle his family as a responsible father. He further said that there is nothing wrong having more than one sexual partner, provided the man is able to provide for them. This position, agrees with what Arnfred talked about; that Men are, expected to perform certain roles, including being sexually aggressive, and they may not see anything wrong in sexual violence and not in other roles, like child rearing, consulting the wife.
on when to or not to have a child, as these were and still are, roles to be performed by women (Arnfred, 2004).

All women in Kibera who participated in the study said their grandmothers, told them that the husband was the head of the family and that it was the wife’s duty to obey him and that it is the responsibility of a man to provide for his family as is expected by the society.

On the other hand, the men who were surveyed said that the female is expected to attend to all household work, like cooking, cleaning, childrearing, and taking-care of her husband. This agrees with what one sociologist said of machismo men; that, “The macho male is not expected to become involved in child rearing, considered to be a woman’s task” (Deyoung, 1994).

All the key informants interviewed were of the opinion that because of the way men and women are socialized when they are young; when boys become men and marry; they would practice what they learned as a young child, as this is reinforced throughout early childhood interactions and socialization, which normally puts men in a position to act as they were taught, so they see nothing wrong.

2.7 Hypotheses

The study used the following hypotheses, that;

i. Men have little knowledge on reproductive health.

ii. There is low level of male participation in reproductive health.

iii. There were obstacles that prevent male participation in reproductive health.

2.8 Definitions of Key Terms

Reproductive health- mean a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so as presented by (WHO, 2000).
Men/male- these words were used interchangeably in this study to mean, adults of male gender who are between 18 and 65 years old.

Participation-The term participation as used in this study referred to the many important roles that men play in the reproductive health of women, either within marriage or consensual union, or within sexual relations of casual or commercial nature. The involvement of men, covers issues like avoiding unwanted pregnancies and the use of family planning methods, transmission of STIs (including HIV/AIDS), support in seeking care, gender-based violence, and power, communication and decision making in sexual and reproductive health matters (Bruijn, 1999).
3.0. CHAPTER THREE: METHODOLOGY

3.1 Introduction

In this chapter, background of the study site is provided, the sampling design highlighted, methods of data collection and analysis are also discussed.

3.2 Research Site

The research site was Kibera slum, situated in Lang’ata Constituency, one of the eight constituencies that make up Nairobi province; other constituencies are Westlands, Embakasi, Starehe, Dagoretti, Kasarani, Kamkunjji and Makadara.

Lang’ata constituency is divided into seven administrative boundaries/locations as follows; Karen location with a population of 13,663; Lang’ata location with a population of 22,555; Sera Ng’ombe location with a population of 66,543; Kibera location with a population of 117,106; Laini Saba location with a population of 72,792; Nairobi West with a population of 59,517 and Mugumoini location with 49,064 people (http://www.information.go.ke/cdf_docs/2003-2006).

Kibera lies at an altitude of 1,670 meters above sea level, latitude 36 degrees, 50 degrees east and longitude 1 degree, 17 degrees south about 140 km south of the equator. The emergence of Kibera as an informal settlement is connected with the phenomenal growth of the city of Nairobi. Kibera slums, the largest informal settlement in Africa, is situated 5 kilometers south of Nairobi City centre which is the capital city of Kenya. It houses more than a quarter of Nairobi’s population. The name 'Kibera' originated from a Nubian word which means 'forest' (Karanja et al., 2002).

The community is divided into nine official villages, with each village having its own elder. They are Kianda, Soweto, Kisumu Ndogo, Lindi, Laini Saba, Siranga, Makina, Gatwekera and Mashimoni. There are no residences greater or bigger than a single storey. The average home is nine square meters, which has five inhabitants per dwelling (Karanja et al., 2002). An effort to
upgrade the slum by the government has not achieved much, only 600 units of two bed roomed houses has been constructed at the decanting site near Langata women’s prisons, while the houses which were left vacant to create space for construction of new houses have already been occupied (Gok/Un-Habitat, 2007)

MAP 1: SITE MAP OF KIBERA

3.2.1 Economic activities, poverty level, fertility rate and average number of children per household

In terms of economic activities, entrepreneurship was an incredibly important skill to Kibera residents as most were self employed, with only 3% being employed in the formal sector. Business was not dominated by one gender, rather the initiative to start a business was relatively equally shared by genders. The most common businesses operating in Kibera were: retail, salon or barber shop, food outlet, open air, and vegetable sales. Lack of capital for business expansion, poor roads, insecurity and financial problems were the major constraints faced by the business community (Courtney, 2005).

Other sources of livelihood include; reliance on casual work in Industrial areas; while majority of women survived on household work from nearby estates, like Ngumo, Langata, Nyayo High-rise, to mention a few, while others also engaged in informal businesses, not to forget the high number of Non-Governmental Organizations operating in the slum, which are also seen as a source of income by the residents (APHRC, 2002).

According to UN-Habitat Urban indicator report of 2003-2004, total fertility rates were lower in urban than in rural areas throughout the world. But this does not mean that all urban women had the same access to reproductive health care, or even that they could all meet their needs for contraception. Poor women within cities were significantly less likely to use contraception and have higher fertility rates than their more affluent counterparts. At times their reproductive health situation more closely resembled that of rural women, fertility rate of Kibera is not different from other slum settlements in Kenya, which is estimated at 4.9, while the average number of children per household is 5 children (KDHS 2003; APHRC, 2002).

In Kibera, there are no government health facilities, but there are those run by charitable and community based organizations, in addition to private individuals. Therefore charitable and community based organizations are the main sources of contraceptives and family planning avenues available to the residents.
3.3 Research Design

The research was an exploratory study; whose objective was to examine the level of male participation in reproductive health in the three (Laini Saba, Kianda and Lindi) villages of Kibera slums. Data was collected at two levels, the household and institutional levels (community based organizations and health facilities in Kibera). The research took a period of three months.

3.4 Sampling

The study population consisted of males and female adults (18-65 years old) living in Kibera and were either married or were in intimate relationships at the time of the study.

The study used stratified random sampling to select sample population. The process of sample selection was based on already existing household census, household clusters and existing women groups in each of the three villages mentioned in (3.3) above.

The sample size for the study was 60 people; with 35 male respondents, 20 female FGD participants and 5 key informants.

The women who participated in the three focused group discussions were conveniently picked from the existing women groups in the three villages, each of the three focused group discussions had between 6-8 participants.

The women were interviewed because; a large proportion of women suffering from a wide range of reproductive health problems had their own insights and opinions on the level and manner of male participation in reproductive health. Their input provided the needed insights which otherwise would not have been captured if they were excluded from the study.

Five key informants were purposely sampled from the existing major health facilities in Kibera. These key informants were; either in-charge of the health facilities, heads of departments or were proposed by, the in-charge of the health facilities after I explained the purpose and
objective of the study. Key informants were people who were knowledgeable on issues of reproductive health and knew what was going on in Kibera. Key informants were interviewed because of their particular knowledge, understanding and experience in handling the subject. They provided useful insights on the topic under study.

The unit of analysis used was the individual men and women who participated in the research.

3.5 Data Collection Methods

3.5.1 Survey technique

This was instrumental in generating quantitative data; Survey questionnaire was developed and administered by the researcher to 35 respondents to generate basic demographic information such as age, level of education, marital status and income among others.

The technique also assisted in generating information on the level of Men’s knowledge on reproductive health, level of male participation in reproductive health, and perceived obstacles to male participation in reproductive health.

3.5.2 In-depth Interview

Three respondents from the questionnaire were subjected to in-depth interviews. They were selected on the basis of their openness and willingness to share their experiences on use or none use of contraceptives as Men with their wives/girlfriends.

This technique was used to seek clarity and further explanation from the three male informants on the answers and responses they had given on a number of issues, especially on their knowledge and level of participation in reproductive health. The technique assisted in encouraging them to elaborate and explain the reasons for some of the answers they had given thus assisting to get clarity for the research questions.
3.5.3 Focused Group Discussions (FGDs)

Three focused group discussions were held, one in each of the three villages, Lindi, Kianda and Laini Saba to generate information from the women. This gave women the opportunity to talk about their concerns regarding male participation in the reproductive arena. The first and second FGDs had six participants while the third had eight participants. This method assisted in generating information on the gap between male and female aspirations and what the actual practice has been as experienced by the women.

3.5.4 Key informant Interviews

In depth interview was used to gather information from five key informants, three of whom were professional medical personnel and two community health workers. The information collected revolved around the level of male participation in reproductive health, men’s knowledge of reproductive health, obstacles to male participation in reproductive health and the best ways to enhance male participation in reproductive health.

This was aimed at, obtaining the specialized knowledge and experience about the research topic. This assisted the researcher to gain insights, which would otherwise not have been given by the other respondents and participants.

3.5.5 Secondary data sources

Secondary data through library and internet search were major sources of information for this research. Relevant literatures concerning male participation in reproductive health were reviewed, especially to provide background information on the topic of study. This provided information for the research problems and hypotheses.

The use of several methods of data collection was justified by the fact that they are complimentary to one another and is therefore, useful in generating in-depth information that may otherwise be difficult to get.
3.6 Data Processing and Analysis

Two sets of data (qualitative and quantitative) were used, and each data was analyzed separately. On qualitative data, there was content analysis in line with the identified themes. Responses were interpreted by looking at the trends and frequencies.

Direct quotations and selected comments from informants and participants were used to give clarity and to amplify the voices of the informants.

Quantitative data were analyzed using the SPSS. The quantitative data were entered and cleaned using SPSS 10 statistical software package for analysis. Tables were generated using the frequencies and percentages from the analysis.

3.7 Ethical Considerations

Ethical principles and rules considered socially accepted were adhered to; in this study, the respondents were informed of the purpose and objective of the research and they participated out of their informed consent without coercion.

A detailed explanation of the expected risks and benefits were elaborated to the respondent; participants and key informants. Participation in the research was voluntary and there were no payments.

In addition, assurance of confidentiality & anonymity was guaranteed to all who took part in the research such that no one reading the report would be able to identify them. Individuals were left to decide what aspects of their lives, attitude, opinions, fears among others they were willing to discuss during the study, right to discontinue or withdraw from participation was granted without having to give reasons to the researcher.

The researcher did a detailed explanation on how the respondents were selected and why it was important for them to participate in the study.
4.0. CHAPTER FOUR: STUDY FINDINGS AND DISCUSSIONS

4.1. Introduction

This chapter presents the findings of the study and the discussion thereof as per the set objectives.

During the interviews, 37 questionnaires were administered, out of which 35 respondents fully cooperated answering the questions. Two respondents declined to be interviewed and are therefore, not part of the results presented here.

4.2 Demographic information of respondents

The demographic information collected included age of respondents, level of education, occupation, marital status and religious affiliation.

4.2.1 Age of respondents

The study involved respondents of ages 18 years and above. The ages were distributed in cluster with a class index of 5. The table below shows the distribution of ages of respondents who participated in the study.

Respondents between ages 26-30 years accounted for 26%, 31-35 years accounted for 14%, 36-40 years were 26% and those above 40 years old accounted for 34%

Table 1: Age of respondents in Years

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-30 years</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>31-35 years</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>36-40 years</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>Above 40 years</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
</tr>
</tbody>
</table>
4.2.2 Level of education

The level of education was considered as one of the variables for determining the level of male participation in reproductive health, as it influenced to a large extent, the knowledge of various family planning methods available to both men and women.

Results indicate that 62.8% of the respondents have a minimum of high school education and above.

Uncompleted primary school education accounted for 9%, those who had completed primary schooling accounted for 11%, uncompleted High school represented 17%, those who had completed high school accounted for 34%, while those with Tertiary education accounted for 26%. The final category was University education, which accounted for 3%.

The table below shows the frequency of the distribution in terms of education

<table>
<thead>
<tr>
<th>Level of education (highest level completed)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school education(not completed)</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Primary school education(completed)</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>High school (not completed)</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>High school (completed)</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Tertiary college</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>University education</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.2.3 Marital status

The total number of married men who participated in the study were 68.6% while those who were in stable relationships but were not married accounted for 31.4% as shown in the table below.
Table 3: Marital Status

<table>
<thead>
<tr>
<th>Duration of Marriage/ relationship</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of Marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2 years</td>
<td>5</td>
<td>14.3</td>
</tr>
<tr>
<td>2-4 years</td>
<td>10</td>
<td>28.6</td>
</tr>
<tr>
<td>4-6 years</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td>Over 6 years</td>
<td>6</td>
<td>17.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of relationship</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 years</td>
<td>8</td>
<td>22.8</td>
</tr>
<tr>
<td>2-4 years</td>
<td>2</td>
<td>5.8</td>
</tr>
<tr>
<td>Over 4 years</td>
<td>1</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.2.4 Main Occupation

The main occupations are small scale businesses (42.9%) and Juakali artisan accounting for 17.1%, while those in formal employment accounted for 11.4%.

The table below shows the frequency of the distribution in occupation of Kibera residents.

Table 4: Occupation

<table>
<thead>
<tr>
<th>Main occupation of residents of Kibera</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juakali artisan</td>
<td>6</td>
<td>17.1</td>
</tr>
<tr>
<td>Business man (Shop-Keeper, grocers, Barber-Shop, food kiosk)</td>
<td>15</td>
<td>42.9</td>
</tr>
<tr>
<td>Formally employed</td>
<td>4</td>
<td>11.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>10</td>
<td>28.6</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
</tr>
</tbody>
</table>
4.3 Level of Male Knowledge on Reproductive Health

Most men (97.1%) who participated in the study had knowledge of several family planning methods, and were able to name the following: condom, sterilization, vasectomy, injectables and abstinence. On the other hand, women in the focused group discussions were able to name most of the methods of family planning which included; male condoms, female condoms, female sterilization, intra-uterine devices (IUD), pills, male sterilization, injectables, implants, lactational amenorrhoea (LAM), observing calendar (safe days) and withdrawal.

Out of the 97% of men who mentioned that they knew various contraceptives used for family planning, less than half (37.1%), said they knew how to use or had ever used male condom, while the rest (60%) did not know how to use male condoms or had never used condoms.

Out of the 37.1% who said they knew how to use condoms, only 28.6% said they use condoms with their wives and girl friends occasionally, but most of the times, used condom when they have sex with commercial sex workers or women they are meeting for the first time. The other three out of the thirteen who knew how to use condoms said they only use it with other women who are not their wives/girlfriends.

Information gathered from key informants indicate that men are more likely to know of methods used by men for family planning, than female methods, while females were more likely to know of methods used by both men and women at the same time.

"Because of lack of knowledge of reproductive health by men, the programme of prevention of mother to child transmission of HIV/AIDS has not achieved the envisaged impact, because HIV positive mothers, were forced by their husbands to breastfeed their young ones, without knowing the dangers they are exposing the children to" (A community health worker in Silanga MSF said).
One clinical officer who works with the *Ushirika Wa Maisha na Maendeleo* (Kianda) clinic, said that men are less informed on most modern contraceptives, referring to the data of patients who seek information on reproductive health from their clinic, 5% were men and 95% were women, he however added that most men in Kibera would know about male condoms.

A doctor from Silanga MSF clinic said that Men need information, counseling and services to address a wide range of problems and concerns related to reproductive health. Many men are poorly informed regarding sexuality and reproduction and need information about male and female anatomy, contraception, STDs and AIDS prevention and women's health care needs during pregnancy and childbirth. They also need confidence and guidance on how to share decisions and negotiate choices with their partners.

"The reason why women are more knowledgeable on modern contraceptives than men is that, most emphasis is placed on them (women), because they have the greatest level of burden and exposure to the risk of pregnancy and sexually transmitted infections, and that most methods of contraception are designed for them" (A doctor from Amref health facility in Kibera said).

This finding is in agreement with the research finding of the KDHS (2008-09), which indicates that, 97% of men aged 15-49 years old know at least on method of family planning. In addition to the finding by KDHS 2008-09, Odhiambo (1997) argued that lack of awareness and misinformation regarding contraception among men also influences the non-acceptance and use of contraception on their wives.

Furthermore, because of lack of knowledge, men often perceive reproductive health problems with shame and embarrassment; and whenever they seek medical treatment, they often visit untrained healthcare providers (Singh et al, 1998).

The study established that knowledge of contraceptives does not necessarily translate to practice and disagrees with the position taken by Zimbardo and Muslach (1977) that, knowledge changes attitude and bring them to practice.
4.4 Level of Male participation in Reproductive Health

Most men are reluctant to participate in reproductive health issues with their wives/girlfriends, the study found that most men do not participate in reproductive health with their wives, but do so with other women who are not their wives or girlfriends. The study found that out of 33 of men (94.3%) who were able to name at least three methods of family planning, only 28.5%, were using condoms with their wives, the other 65.7% did not use any of the methods of family planning with their spouses. One informant said that, “when a man uses condom with his wife, the wife is likely to suspect that the husband is having an extra marital affair and vis-versa which may cause mistrust and tension in the family”.

The 65.7% not participating in reproductive health justified their positions giving reasons, such as lack of time, devices for men not readily available, and where they are, the cost is prohibiting. Some said they are still young in the marriage and wanted to have children before they start thinking of family planning, while others maintained that family planning was the responsibility of women. On safe sex, they confessed that sex is not fulfilling when contraceptives are used and that using contraceptive would breed mistrust and unfaithfulness in the marriage.

This conforms to the position taken by Changanti (1994) on the dominant male view that, condoms as a method of family planning is associated with unfaithfulness and therefore not acceptable in most stable sexual relationships. The introduction of condom use in a long-term relationship, where they have not been previously used, may threaten the trust that is implied (whether it exists or not) in most of such relationships, and that for most married men and women, condoms were associated with outside partners hence should be used only for casual sex and with prostitutes (Changanti, 1994:38).

On the other hand, 28.5% of those interviewed said that they participated in reproductive health, in one form or another; the most preferred methods included the use of condoms, discussions with spouse about reproductive health matters and encouraging the wife to use various family planning methods.
Vasectomy as a method of family planning, did not receive a lot of support from men interviewed, 85.7% did not support it, while 14.3% supported it as a method of family planning. Those who did not support it argued that it would permanently deny a man his reproductive ability/security. Security in terms of male ability to impregnate a woman in a new marriage or relationship, or in the event the current wife dies, the man would want to remarry and may not be able to father babies.

There are some who said, vasectomy would make a man lose his sexual drive thus becoming weak sexually. Religious believes also accounted for a significant percentage of those who would not support vasectomy.

The table below illustrates various reasons given by men for not supporting vasectomy as a method of family planning.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Against Religious teachings</td>
<td>10</td>
</tr>
<tr>
<td>For reproduction security (ability to impregnate a woman)</td>
<td>16</td>
</tr>
<tr>
<td>Make a man weak sexually (loss of libido)</td>
<td>3</td>
</tr>
<tr>
<td>They should use condoms instead</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect against pregnancy with other sexual partners</td>
<td>3</td>
</tr>
<tr>
<td>Protect the health of wife</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

Results from the three FGDs indicate that most men were reluctant to participate in reproductive health issues, especially the use of family planning methods.

“Even if one knows that the husband/boyfriend has an extra marital affair, it is not easy to ask him to use a condom as this may result into beatings”. (A 40 years old mother of three, a participant in one of the FGDs said)
Such sentiments is echoed by Arnfred (2004) that, “it is difficult, perhaps almost impossible for women (married women in particular) to negotiate safe sex measures....women agree that to ask the husband to use a condom-when they know that he has been with other partners-would be to disclose their disrespect too openly...the common argument from both Nyumba Ndogos (mistress/concubines) as well as ‘wives’ were that if they insisted on condom use, their partners/husband would be suspicious and then have a reason to accuse them of not being faithful” (Arnfred, 2004:239).

Women in the Laini Saba FGD reported that, whenever they tried to encourage their husbands to take an interest in reproductive health, the husbands reminded them that, it was a woman’s responsibility to ensure that they do not just become pregnant all the time. This confirmed the result of the men surveyed who said that the main role of a man in reproduction is to impregnate the woman and wait for the child to be born, the rest of the reproductive health issues are for the women to handle.

Majority of women who participated in the FGDs said they would advise their husbands to participate in family planning, once they have at least two children, to avoid having many children that one cannot manage.

Male respondents who supported (28.5%) male involvement in reproductive health had the following reasons; that men and women have equal responsibility to plan their families, and that reproductive health has become a way of life, therefore requires the participation of both, in addition to the fact that most men are the heads of the family, thus must play active role so as to, provide leadership and to have a family size that they can easily provide for and support.

Results from the three focused group discussions underscored the importance of male involvement in reproductive health, given their central role in decision making in the family.

“Men are the heads of families in most cases, their participation in reproductive health is critical as they make most decisions in the family, including when to have a child and what hospital to go to for prenatal and post-natal care” (A 33 year old mother of 4, a participant in one of the FGDs said).
In recognition of the critical role of men in reproductive health, a health facility in Kibera tried a programme that was intended to encourage male participation in reproductive health, because men were difficult to reach; the hospital opted to reach men through their wives. The women who visited the health facility would be given condoms to take home and were expected to convince their husbands to use them.

"men refused to use the condoms: some of the women who had been given condoms to take home, were brought back to the clinic by their husbands to confirm if it was true that, the condoms had been distributed by the clinic, this threatened to break several families, so we had to stop the programme" (A doctor at the health facility said).

The finding is in concurrence, with that of Wamalwa and Nyajom (2004), who documented that because of cultural reasons in western Kenya, a woman is usually not supposed to see a man who is the head of the family naked and that, one is not supposed to let other people know that they are planning to have sex. Therefore, purchasing condoms from local shops or vendors is a major feat that is achieved by only a few since it amounts to an open announcement about one's intentions as far as sex is concerned.

The finding demonstrates the low level of male participation in reproductive health. From the study findings, there is no good reason that would make men to be reluctant in participating in reproductive health issues. Especially safe sex and family planning, on the contrary, the participation of men would bring more benefits to the family and the women, the need for men’s participation has become increasingly urgent, especially in the era of the growing widespread cases of sexually transmitted diseases (STDs), including HIV infection.

4.5 Obstacles to Male participation in Reproductive Health

Some of the obstacles that were found as hindrances to male participation in reproductive health included; lack of proper information or misinformation, lack of health facilities for men’s
reproductive health needs, traditional values attached to children in African context, negative association of contraceptive use in a marriage or stable relationships and religious beliefs and practices.

**Lack of proper information and knowledge of reproductive health**; majority of men believed that vasectomy causes impotence or makes men weak. In this study, most respondents reported hearing negative comments about vasectomy, mostly from friends.

Out of the 35 men interviewed, 8.6% thought vasectomy would reduce a man’s sexual libido and therefore would not support it as a method of family planning. When the men were probed on their understanding of vasectomy, they thought it is very painful and equated it to castration of male animals.

Results from the three FGDs with the women indicate that most women were able to name several contraceptives used for family planning compared to men. The inability by most men to name various contraceptives used for family planning may be a contributing factor to the reluctance by men to allow their spouses to use contraceptives.

This finding concurs with the results from the study by Passara (1992) who revealed that contraceptive knowledge significantly related to selection of contraceptive method, while good knowledge of maternal and child health by the husband promoted more ante-natal care and increased men’s participation (Passara, 1992:92).

Further, information from health professionals in Kibera proved that men do not have proper information on vasectomy;

"vasectomy is a simple, effective and safe surgical procedure for permanent male fertility control, the procedure simply interrupts the delivery of sperms; it has no effect on either the production of male sex hormones or their secretion into the bloodstream, therefore sexual libido and ability to have an erection and orgasm with ejaculation are not affected". And that “men are reluctant to participate in reproductive health and family planning because; “Men either lacked proper information or had wrong information on reproductive health and family planning” (a doctor at the Amref health facility in Kibera said).
Therefore, the low level of participation by men in reproductive health was as a result of misinformation, wrong information and or reluctance by men, as most men view reproductive health as the responsibility of women.

From the above, it can be concluded that lack of knowledge and information is a contributing factor to the lack of male participation in reproductive health, though having knowledge of reproductive health does not automatically translate into use of the same by men with their wives/girlfriends.

**Lack of health facilities for men's reproductive health needs;** most men who participated in the study pointed out that there are no male reproductive health facilities in the area, as opposed to those for women.

"It is difficult and embarrassing to struggle with women in the queue for reproductive health services, in facilities that are designed and equipped to respond to women's reproductive issues" (a 47-year-old father of four, said during the interview).

Evidence from focused group discussions show that men were reluctant to seek reproductive health services from health facilities because; there were no special facilities for men; Women in the focused group discussions in Lindi and Laini Saba said that it was difficult to convince their husbands or boyfriends to seek medical attention in the public health facilities in Kibera; as the men said that the facilities are designed for women, furthermore, very few men are seen going to seek reproductive health services in such facilities.

Interviews with key informants revealed that, Men are reluctant to seek reproductive health services; because they view the facilities as ‘women’s place’.

"Men's health seeking behavior, especially in regards to reproductive health, is influenced by the availability of male friendly reproductive health facilities" (a female clinical officer in Kianda said).
This reflects the results by Ndong et al (1999), who documented that family planning services have typically been provided through speciality areas of hospitals (i.e.: obstetrics and gynaecology) or specialist community services (i.e: family planning clinics, maternal and child health clinics). There exists no comparable arena of reproductive service delivery for men. (Ndong et al 1999).

According to a doctor at Lindi-Silanga (MSF) health facility, the reproductive health wing of their facilities were designed to respond to women’s reproductive health systems, because most of their clients with reproductive health complications were women, though even men can be served in the same facility, but not many cases are attended to.

**Traditional values attached to children in the African context;** majority of men surveyed (75%), noted that their motivation to have many children is related to the value and benefits of children. Some of the reasons advanced by such men included; children are a source of joy and pride; a source of financial support in old age and a means to receive a decent burial when one dies. This is why they are reluctant to participate in reproductive health programmes (family planning) that limit the potential number of offsprings.

Evidence from the three FGDs indicate that women were keen in protecting their marriage by ensuring that they gave birth to several children (boys and girls), this would assure them of their security in old age. The children, especially boys would protect them from being chased away from their matrimonial homes or property by either their husbands or in-laws, while the daughter would take care of them in-terms of their means of survival.

Key informants experiences show that, most people still attach a lot of value to children. Information gathered from interviews with health professionals indicate that many married couples are ready to do everything within their means, including consulting witch-doctors and faith healers in a bid to have the curse of barrenness removed so as to get children. A doctor from one of the facilities in Kibera said that “several women have died in Kibera and others treated from taking unknown concoctions in an effort to treat barrenness, a testimony to the value attached to children by couples”.


The finding agrees with the documented results by Fapohunda.B.M et al (1999) that Men and women were also concerned with old age security. In particular, women earn social security, esteem, and respect from having many children; and the need to bear many children especially if the husband or wife came from a small family is a major constraint to family planning (Fapohunda.B.M. et al 1999).

**Negative association of contraceptive use in a marriage;** men who oppose contraceptive use said that it can undermine their authority as heads of the households when the wife has to decide when to become pregnant and when not to; and that, the wives, will be unfaithful and may become promiscuous.

Most men who participated in the study said that condom is frequently used when one has sexual intercourse with prostitutes and unfamiliar women, in rare occasions, do men use condoms with their wives or girl friends.

"Condom is used with prostitutes or strangers, but with your wife" (a 35 year old, father of one child, from Kianda village, said).

The three focused group discussions revealed that it is hard to ask the husband or boyfriend to use a condom, as this may be interpreted by the husband to mean that, the woman is not faithful in the marriage or relationship. The women also said that, their men complain that using a condom while having sex, reduces the pleasure and equates it to eating a sweet with the wrapper on.

The key informants noted that the level of acceptance of condom and or other contraceptives use in marriages and stable relationships is a challenge, as most partners are reluctant to use contraceptive in their marriages for fear of betraying their trust and causing suspicion in their relationships. This finding resonates with the finding of Watkins, S.C, et al (2003) that condom use is associated with sex with a commercial sex-worker and extramarital sex is perceived as the most serious source of HIV-infection.
Religious beliefs; majority of men (74.3%) opposed family planning because of their religious affiliation, while others believe that children are a gift from God and therefore, should be accepted without reservation, some men went further to cite the scriptures and commandments that man was directed to go into the world, multiply and conquer it, so planning family through artificial methods would be going against religious teachings and the will of God.

Results from the three FGDs were not very different, religion is a major factor in determining the use or non-use of contraceptives in marriages or intimate relationships; most women said that because of their religious beliefs, it would be difficult to start even discussing the issue of contraceptives with their husbands. They maintained that religious teachings were against family planning and use of contraceptives. They further reported that their husbands do not like using condoms because it is like throwing away their sperms which is equivalent to killing the unborn children, which is against the religious teachings.

“It is a taboo and against the Muslim religion to discuss women's reproductive health issues outside the marriage institution, and more so, with other male members of the society including a doctor” (A 35-year-old Muslim mother of two from Lindi in a focused group discussion, said).

“Health professionals have been accused by religious leaders of promoting pre-marital sex, by availing free contraceptives in their health facilities which they (religious leaders), equate to licensing pre-marital sex, which is against religious teachings, beliefs and practices” (A doctor at one of the health facilities in Kibera said.)

“Among the Muslims, it is against their religion for a male doctor to attend to a female patient and even if the woman would be willing, the husband would not allow”; (said the doctor).

According to the Bible, the use of contraception was not allowed; this informs the position of the Catholic Church. The Bible mentions at least one form of contraception specifically and condemns it. Coitus interruptus, was used by Onan to avoid fulfilling his duty according to the
ancient Jewish law of fathering children for one’s dead brother (Gen. 38:8–10), while the doctrine of Islam has often been interpreted to forbid the use of family planning methods (Obermeyer 1994).

4.6 How to increase male participation in Reproductive Health

From the study, the following were the suggested approaches to increase male participation in reproductive health; there is need for public education targeting men (campaigns focused towards men and tailored specifically for men should be conducted), this will present an opportunity for men to acquire more information and knowledge on reproductive health issues.

A deliberate effort targeting men for training on reproductive health, would be required as was explained by a doctor in one of the health facilities in Kibera, where, men could not use condoms brought home by their wives; it is easier for the man to bring home the idea of family planning or safe sex and for it to be accepted than it is for the woman.

In terms of strategy in targeting men, they should be trained when they are still young, using various methods of information, education and communication materials; at home, in schools, churches and through health facilities; on the importance of participating in reproductive health issues.

The study revealed that because of socialization, partners find it difficult to discuss freely issues of reproductive health; the doctor from Amref suggested that to overcome this, both men and women needed guidance and counseling to be able to communicate their reproductive health concerns freely.

To address the low level of men’s participation in reproductive health, information, education and communication materials must be designed to target men and women together; this will address the problem of lack of information or misinformation among men.
There is need to set up male clinics that would provide reproductive health services to men; this would deal with the current problem of lack of reproductive health facilities for men.

The government needs to develop policy and guidelines with incentives for men to participate in reproductive health and introduce contraceptive injections for men just as for women; this may increase male involvement in reproductive health issues.
5.0 CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction
This section contains summary of the findings, conclusions derived from the results and the set of recommendations thereof.

5.2 Summary

The study findings indicate that most men are knowledgeable on contraceptives and reproductive health issues. The most widely known contraceptives by men are those used by men themselves; however this knowledge is hardly put in practice, especially in their families. The level of knowledge is influenced by among other factors, the level of education, access to information and the income level of an individual.

The level of male participation in reproductive health is still low, though there are prospects of attracting more men to appreciate the need for their participation in reproductive health. This is due to increased level of education and the information men receive through mass media, awareness programmes and education materials produced by organizations working on health related programmmes in Kibera.

The obstacles to male participation in reproductive health; are more of structural in nature, the study found out that health facilities are not friendly to male partners, especially on reproductive health services. The other obstacle is socialization; men are socialized that reproductive health issues (family planning) is the responsibility of women and not men. Overcoming this kind of socialization in a patriarchal society such as Kenya is difficult and takes time, thus it slows down the level of male participation in reproductive health.

5.3 Conclusions

A number of underutilized opportunities available to men can be utilized to influence and improve the health choices for family members, especially women and children. These include assess capacities and capability of the existing Reproductive Health institutions in delivery of
Reproductive Health Services to both men and women, so that structural issues of inadequate facilities can be addressed.

The general trend is that, education has a great impact on knowledge and attitudes about Family planning and safe sex as practiced by both men and women, this does not automatically translate to male participation in reproductive health issues with their spouses or partners. This may be an important topic for further enquiry.

The decision by a couple on family planning method or contraceptive use is influenced by the frequency and the amount of time set aside by the couple to discuss the subject. This is important for the approval of family planning and eventual practice of a method, by both husband and wife/girlfriend.

5.4 Recommendations

From the study findings, the level of Men’s knowledge of reproductive health is not as low as had been thought, what is needed, are programmes and strategies, which specifically targets men, so that they can translate their knowledge on reproductive health into use with their wives/girlfriends.

Most of the hospitals and health facilities were found not to be male friendly; it is therefore recommended that male friendly health facilities should be established as this may motivate men to seek medical attention when challenged with reproductive health complications, like sexually transmitted infections.

Men need to be targeted for training on reproductive health, because it is easier for the man to bring the idea of family planning or safe sex home and for it to be accepted than it is for the woman, this will address cases where women are threatened by their husbands when they are found to be using family planning methods or contraceptives.

There is need to improve effective communication between partners, this will enable spouses to discuss and take collective decisions on contraceptive use for fertility regulation.
Finally, to ensure increased male involvement in health issues especially reproductive health, relevant institutions could take various steps; first is to learn more about what Kenyan men know, think and need when it comes to men's reproductive health concerns. Secondly, design more reproductive health programs that involve men and educate them about reproductive health, their own responsibilities and needs. And thirdly, the government should work with all stakeholders in the health sector to develop guidelines that would promote male involvement in reproductive health and provide a sound framework for financing such programmes.
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APPENDICES

APPENDIX 1: INTRODUCTION AND INFORMED CONSENT

Hallo, my name is Elijah Ochieng Odhiambo. I am a student at the University of Nairobi, pursuing a master degree in Gender and Development. I am currently collecting data on the role of men in promoting women reproductive health.

The purpose for this study is aimed at establishing the level of male participation in reproductive health (Safe sex and family planning) in Kibera, the level of male knowledge in reproductive health, obstacles to male participation in reproductive health and suggests strategies of how to deal with obstacles identified.

I hope the information you will provide will help to inform policy makers on strategies to improve male participation in reproductive health.

In order to get this information, I would like to request your permission to respond to a few questions, and or to share your knowledge and experience on the role of male in reproductive health in Kibera.

The interview will request for personal information such as age, marital status, level of education and income.

Benefits
This study will have no immediate and direct benefit to you; however the information provided by you will be used to make specific recommendations for policy makers and implementers on the subject. This is hoped will have a long term benefit to both men and women in Kibera and to the world as a whole.

Sharing the results
After the assessment is completed and the project paper is approved by the University of Nairobi, a copy of the project report will be given to the University of Nairobi, a copy will be given to me. If you would like to receive a copy of the report, i can be informed and i will make this possible for you.

Consent
Do you have any questions that you would like to ask?
Is there anything you would like me to explain or elaborate on?
Do you agree to take part in this interview sessions? You have the freedom to accept or decline.
If yes, then may we start?
If no, then, thank you for your time, and in case you change your mind, here is my contact.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it, and the questions I have asked have been answered satisfactorily. I therefore consent voluntarily to participate in this study.

Contact details
If you have any other questions about this study later, you can contact any of the following persons:
1. Dr. Owuor Olungah, Lecturer-Department of Gender and Development Studies, Institute of Gender, Anthropology and African Studies, University of Nairobi, P.O. Box 30197 Nairobi, Mobile phone: +254 722217132, email address: cmcolungah@yahoo.co.uk

2. Elijah Ochieng Odhiambo, P.O. Box 6393-00200 Nairobi, Mobile phone: +254-722 231162, email address: odhiamboo69@yahoo.co.uk
APPENDIX 2: SURVEY QUESTIONNAIRE

This was used to collect information from systematically sampled respondents (men) from Kibera

Part i-General information about the study and the researcher

Self introduction, detailing my full names, the Institute where am currently studying, then share my full contact (phone and postal address).

An explanation as to the reasons and purpose of the study would then follow. In this case explaining the background of the study

Men's participation in reproductive health in Kibera

This study aims at establishing the level of male participation in reproductive health (Safe sex and family planning) in Kibera. What are some of the obstacles to male participation in reproductive health and how can the obstacles be tackled.

The information collected through this questionnaire, will assist to develop strategies that would encourage male participation in reproductive health, especially to influence programmes and policy formulation. The potential benefit that you shall gain is that you will have a feedback session to validate the information you have shared and get a copy of the research findings once completed and approved.

As an ethical and professional requirement, I'm bound by the guidelines of the University to protect the identity of my informant at all times, this will be ensured.

The information given will be treated with utmost confidentiality; if it has to be shared i shall have to seek written and verbal consent from you (the informant).

The questionnaire has most open-ended questions to enable the respondents give their opinions as widely and openly as possible.

Part ii: Background information

1. Interviewer’s name
2. Interviewee’s name Optional.................................................................
   Contact..........
3. Area/place of interview (village/sub-location/location)..............................
4. Age of respondent (please tick the appropriate box):
   a) Under 18 years [ ]
   b) 20-25 years [ ]
   c) 26-30 years [ ]

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d) 31-40 years [ ]
e) 36-40 years [ ]
f) Above 40 years [ ]

5. Level of education (highest level completed):
   a) No formal education at all [ ]
   b) Primary school education (not completed) [ ]
   c) Primary school education (completed) [ ]
   d) High school but not completed [ ]
   e) High school (completed) [ ]
   f) University education [ ]
   g) Other professional skills/training (please specify) .............................................

6. What is your main occupation?
   a) Juakali artisan [ ]
   b) Business man (please specify) .........................................................
   c) CSO (Please specify) .................................................................
   d) Government employee (specify) .....................................................
   e) Private firm (please specify) .........................................................
   f) Others (specify) .............................................................................

7. What is your average monthly income?
   a) Below Ksh. 5,000/= [ ]
   b) 5,000-10,000 [ ]
   c) 10,000-20,000 [ ]
   d) Above 20,000 [ ]

8. Duration of Marriage/relationship
   a) 0-2 years
   b) 2-4 years
   c) 4-6 years
   d) Over 6 years
9. Number of Children?

<table>
<thead>
<tr>
<th>Age (years old)</th>
<th>Number of children</th>
</tr>
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<tbody>
<tr>
<td>0-2</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td></td>
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<tr>
<td>4-6</td>
<td></td>
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<tr>
<td>Over 6</td>
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10. At present, are you planning to have a child?

Yes [ ]  No [ ]

Knowledge and information sources on reproductive health

Exposure to mass media and other sources of information on reproductive health in the last three months

1. Do you receive information about safe sex and family planning?
   Yes [ ]  No [ ]

2. If yes, how often do you receive information or communication about safe sex and family planning?
   Once a month [ ]  once a week [ ]  almost daily [ ], daily [ ]

3. What is/are the source(s) of your information
   i. Television
   ii. Radio
   iii. News papers/magazine
   iv. Leaflets/posters
   v. Relatives
   vi. Friends/other people not medical personnel
   vii. Medical personnel
   viii. Others (specify)

4. If your answer is no in (1 above), please elaborate why you do not receive information about reproductive health (safe sex and family planning)

5. Name the various male and female contraceptives that you know.
Level of male participation in reproductive health

1. Do you participate in any reproductive health issues with your spouse?
   Yes [ ] No [ ]

2. If yes, in what way(s)?

3. If No, is there any reason why you do not participate in reproductive health?

4. Should men participate in family planning and if so, why? If not, why shouldn’t they participate?

5. Of the male contraceptives named (if not researcher will give examples) is there any that you or your wife/girlfriend have used/or currently using?

6. Should men be encouraged to go for vasectomy as a method of family planning? If yes, why and if no, please give reason(s).

7. Men are said to be polygamous by nature, do you agree or not agree with this statement? Please support your answer.

Obstacles to Male participation in reproductive health

8. Are there any reasons why men should not participate in reproductive health?
   Yes [ ] No [ ]

9. If yes, what are these reason(s)?

10. If No, what are your reason(s)?

Enhancing male participation in reproductive health

11. What approaches can be put in place to enhance male participation in reproductive health?
APPENDIX 3: INTERVIEW GUIDE FOR FGD WITH FEMALE PARTICIPANTS

Men’s Knowledge of Reproductive Health

1. Name the various male and female contraceptives that you know, you have used or currently using with your husband/boyfriend.
2. In your opinion, what is the level of men’s knowledge on issues of reproductive health in Kibera?
3. Is it important for men to participate in reproductive health and why?
4. Do your husband/boy-friends participate in reproductive health issues or not? If he does in what way (s)?
5. Any further insights you may want to share regarding men’s knowledge of reproductive health?

Level of male participation in reproductive health in Kibera

6. In your opinion what would you say to be the level of male participation in reproductive health in Kibera?

Obstacles to male participation in reproductive health

7. In your opinion, are there any obstacles to male participation in reproductive health?
8. What do men say to be the obstacles to their participation in reproductive health?
9. Would you advise your spouse to undergo vasectomy? If yes, why and if no, please give reasons
10. Any further comments on obstacles to male participation in reproductive health?

Approaches to enhance male participation

11. What are the benefits of having men participate in reproductive health?
12. What are the best approaches to increase male participation in reproductive health?
13. Any recommendation on what needs to be done to enhance male participation in reproductive health.
APPENDIX 4: INTERVIEW GUIDE FOR IN-DEPTH INTERVIEW WITH SELECTED MALE RESPONDENTS

1. During the survey questionnaire, your position on male participation was very open and firm, in your opinion that men should/should not participate in reproductive health, could you please support your position?

2. For those supporting the use of contraceptives, which method of contraceptive you have are using or ever used before, state whether with your wife/girlfriend or other women other than the wife/girlfriend and reasons for your response.

3. What are some of the sources of contraceptives in Kibera, how well do people know about their availability and how to use them?

4. For those not supporting the use of contraceptives, why are you against contraceptive use?

5. Why do most men in Kibera, equate reproductive health with women?

6. What should be done to ensure that both men and women appreciate their reproductive health roles is the society, especially in their families?

7. Any other opinion, insights that you think you need to add or elaborate on the topic?
APPENDIX 5: INTERVIEW GUIDE FOR KEY INFORMANTS

1. What is the level of male knowledge of reproductive health issues?

2. To what extend do men participate in reproductive health issues in Kibera?

3. What would you consider to be some of the obstacles to male participation in reproductive health if any?

4. How can the obstacles be addressed to improve male participation in reproductive health?